

§ 457.560

copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(d) *Non-emergency use of the emergency room.* For Federal FY 2009, for targeted low-income children whose household income is from 101 to 150 percent of the FPL, the State may charge up to twice the charge for non-institutional services, up to a maximum amount of \$11.35 for services furnished in a hospital emergency room if those services are not emergency services as defined in § 457.10. Thereafter, any charge may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(e) *Standard copayment amount.* For targeted low-income children whose household income is from 101 to 150 percent of the FPL, a standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in paragraphs (a), (b), and (c) of this section to the State's average or typical payment for that service.

[66 FR 2681, Jan. 11, 2001, as amended at 73 FR 71854, Nov. 25, 2008; 75 FR 30265, May 28, 2010]

§ 457.560 Cumulative cost-sharing maximum.

(a) A State may not impose premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges that, in the aggregate, exceed 5 percent of a family's total income for the length of a child's eligibility period in the State.

(b) The State must inform the enrollee's family in writing and orally if appropriate of their individual cumulative cost-sharing maximum amount at the time of enrollment and reenrollment.

[66 FR 2681, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

42 CFR Ch. IV (10–1–21 Edition)

§ 457.570 Disenrollment protections.

(a) The State must give enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.

(b) The disenrollment process must afford the enrollee an opportunity to show that the enrollee's household income has declined prior to disenrollment for non payment of cost-sharing charges, and in the event that such a showing indicates that the enrollee may have become eligible for Medicaid or for a lower level of cost sharing, the State must facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate.

(c) The State must ensure that disenrollment policies, such as policies related to non-payment of premiums, do not present barriers to the timely determination of eligibility and enrollment in coverage of an eligible child in the appropriate insurance affordability program. A State may not—

(1) Establish a premium lock-out period that exceeds 90-days in accordance with § 457.10 of this part.

(2) Continue to impose a premium lock-out period after a child's past due premiums have been paid.

(3) Require the collection of past due premiums or enrollment fees as a condition of eligibility for reenrollment once the State-defined lock out period has expired, regardless of the length of the lock-out period.

(d) The State must provide the enrollee with an opportunity for an impartial review to address disenrollment from the program in accordance with § 457.1130(a)(3).

[66 FR 2681, Jan. 11, 2001, as amended at 78 FR 42312, July 15, 2013]

Subpart F—Payments to States

§ 457.600 Purpose and basis of this subpart.

This subpart interprets and implements—

(a) Section 2104 of the Act which specifies the total allotment amount available for allotment to each State for child health assistance for fiscal years 1998 through 2015, the formula for